6. Medical Care and Any Other Type of Remedial Care

d. Other practitioners' services

Anesthesia Services

Limited to the anesthesia services provided by nurse anesthetists when such services are within the scope of practice of the nurse anesthetist and are covered anesthesia services in the Medical Assistance Program.

Advanced Registered Nurse Practitioner (ARNP) Services

(1) Covered services shall include those furnished by a licensed participating advanced registered nurse practitioner (ARNP) to eligible Medical Assistance recipients through direct patient contact. Services shall be those which are within the scope of their practice as a licensed ARNP so long as the services are covered in the Medicaid Program.

(2) ARNPs participating as nurse-midwives or nurse anesthesists shall comply with the service requirements of those components for participation and reimbursement, as appropriate.

(3) An ARNP desiring to participate in the Medical Assistance Program shall:

(a) Meet all applicable requirements of state laws and conditions for practice as a licensed ARNP. A current copy of the ARNP's license shall accompany each participation application;

(b) Enter into a provider agreement with the Cabinet for Human Resources, Department for Medicaid Services to provide ARNP services; and

(c) Provide and bill for the services in accordance with the terms and conditions of the provider participation agreement.

(4) Service Limitations are:

(a) Limitations applicable with regard to services provided by physicians shall also be applicable with regard to ARNPs.

(b) Immunizations provided by ARNPs are not covered.

(c) When an ARNP and a physician perform the same service on the same day within a common practice, only one (1) of the services shall be covered.

(d) When an ARNP provides and bills an office visit, an office visit or consultation by a physician in a common practice with the ARNP for a visit by the same patient on the same day is not covered. When a physician(s) provides and bills an office visit, an office visit or consultation by an ARNP in a common practice with the physician for a visit by the same patient on the same day is not covered.

(e) When an ARNP refers a patient to a physician based on medical necessity, the necessity for the referral shall be documented in the patient's record or chart.

Other Licensed Practitioners' Services (continued)

(d) Ophthalmic dispensers' services, limited to dispensing service or a repair service (for eyeglasses provided to eligible recipients), are covered. The following limitations are also applicable.

(1) Telephone contacts are not covered;

(2) Contact lens are not covered;

(3) Safety glasses are covered when medically necessary subject to prior authorization requirements described in material on file in the state agency.

7. Home Health Care Services

7.a. Intermittent or Part-Time Nursing Service

1. There are no limitations on the intermittent or part-time nursing service provided by the home health agency.

2. There are no limitations on the intermittent or part-time nursing service provided by the registered nurse when no home health agency exists in the area except that the registered nurse must be approved by the local health department serving that area as capable of performing the service.

3. Home health agencies may provide disposable medical supplies necessary for, or related to, the provision of intermittent or part-time nursing service as specified for coverage by the Medicaid Program.

7.c. Medical Supplies, Equipment, and Appliances Suitable for Use in the Home

Each provider desiring to participate as a durable medical equipment, appliance, and medical supplies provider must be a Medicare participating provider (except that for the period of October 1, 1993 through March 31, 1994, the provider is not required to be participating in Medicare if the provider is also participating in the Medicaid Program as another type of provider), and sign a provider agreement with the Cabinet for Human Resources, Department for Medicaid Services.

Durable medical equipment, appliances, and medical supplies are covered only in accordance with the following conditions:

1. The equipment, appliances, or supplies which are covered shall be limited to those covered in the Medicare Program unless separately specified for coverage by the cabinet. Any equipment or appliance with a cost of $150 or more must be preauthorized by the cabinet.

2. The equipment, appliances, or supplies shall be ordered by the physician as required in the treatment of the patient.

3. The equipment, appliances, or supplies shall be suitable for the patient to use in the home.

4. The recipient utilizing the equipment, appliances, or supplies shall be Medicaid eligible, and the durable medical equipment providers shall be required to participate as providers in both the Medicare and Medicaid Programs.

5. Coverage for an item of durable medical equipment or appliance shall be in accordance with the following guidelines: that the item shall be durable in nature and able to stand repeated use; serve a medical purpose; generally be not useful to a person in the absence of illness or injury; be appropriate for use in the home; and be necessary, appropriate and reasonable for treatment of an illness or injury or to improve the functioning of a malformed body member. This definition includes but is not limited to wheelchairs, crutches, walkers, intermittent positive pressure breathing machines, braces, artificial limbs, and oxygen (when such oxygen supply can be maintained, replaced, or resupplied at all times). The Medicare Program will be used as a guide for determining the appropriateness for coverage, where applicable.

The following general types of equipment or appliance are excluded from coverage under durable medical equipment or appliances.

1. Items of equipment or appliances which would appropriately be considered for coverage only through other sections of the Medical Assistance Program, such as lens and frames, hearing aides, and pacemakers.

2. Equipment or appliances which are primarily and customarily used for a non-medical purpose, such as air conditioners, room heaters, and humidifiers.

3. Physical fitness equipment, such as exercycles.

4. Equipment or appliances which basically serve comfort or convenience functions or are primarily for convenience of the person caring for the patient, such as elevators and stairway elevator.

7.d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

1. Audiology services are not provided under this component.

2. Physical therapy, occupational therapy, or speech pathology services provided by a medical rehabilitation facility are not provided under this component.

9. Clinic Services

Coverage for clinic services is limited to services provided by the following clinics and includes:

1. Mental Health Centers licensed in accordance with applicable state laws and regulations. However, services rendered by Community Mental Health Centers to Skilled Nursing or Intermediate Care Facility patients/residents are not covered.

2. Family Planning Clinics.

3. Clinics engaging in screening for the purposes of the early and periodic screening, diagnosis and treatment component of the Medical Assistance Program.

4. Outpatient Surgical Clinics.

5. Other clinics authorized under 42 CFR 440.90

9. Clinic Services (continued)

Abortion services are reimbursable under the Medical Assistance Program only when service to provide an abortion or induce miscarriage is, in the opinion of a physician, necessary for the preservation of the life of the woman seeking such treatment or to comply with the federal court order in the case of Hope vs. Childers. Any request for program payment for an abortion or induced miscarriage must be justified by a signed physician certification documenting that in the physician's opinion the appropriate circumstances, as outlined in sentence one of this paragraph, existed. A copy of the completed certification form and an operative report shall accompany each claim submitted for payment. However, when medical services not routinely related to the uncovered abortion service are required, the utilization of an uncovered abortion service shall not preclude the recipient from receipt of medical services normally available through the Medical Assistance Program.

10. Dental Services

A. A listing of dental services available to recipients age 21 and over is also maintained at the central office of the single state agency and is shown in the provider manual.

B. Out-of-Hospital Care

A listing of dental services available to Medicaid recipients is maintained at the central office of the single state agency and is shown in the provider manual.

C. In-Hospital Care

Coverage for services rendered by dentists for hospital inpatient care is limited to services for patients that are determined to be medically necessary. This includes, but is not limited to, patients with:

1) Heart disease
2) Respiratory disease
3) Chronic bleeder
4) Uncontrollable patient (retardate-emotionally disturbed)
5) Other (care accident, high temperature, massive infection, etc.)

D. Oral Surgeon Services

A listing of oral surgeon services available to Medicaid recipients is maintained at the central office of the single state agency and is shown in the provider manual.